INDIANA ACADEMY OF FAMILY PHYSICIANS

IAFP Research Day – Examples of Successful Abstracts

Original Research Category

ASSESSMENT OF BARRIERS MEDICAL PROFESSIONALS FACE WHEN REPORTING CHILD ABUSE/NEGLECT - Primary Author: Justin Grannell, DO; Co-Authors: Jason Tanner, MD; Meg Wilson, PhD; Deborah McMahan, MD; Jana Sanders, Men | Fort Wayne Medical Education Program, Fort Wayne

Objective

- More than five children die every day in the US as a result of child abuse and approximately 80% of children who die from abuse are under the age of three.
- Recent studies have shown that over half of medical professionals do not report all cases of suspected abuse due to many barriers (knowledge deficits, lack of certainty, concern for the child, etc).
- The purpose of this study was to identify barriers for identification and reporting child abuse/neglect including level of difficulty, comfort level, and usual course of action by diverse medical professionals in order to provide insight for educational interventions.

Design

- Descriptive and cross sectional
- Internet based 22 item questionnaire using Survey Monkey

Setting

- Inpatient, outpatient, and community settings in Northeast Indiana Subjects
- Medical pediatric care providers: Physicians, Nurse Practitioners, Physician Assistants, Nurses, Medical Assistants, Dentists, and Dental Hygienists

Intervention

- None

Main Outcome Measure

- Demographics, barriers to reporting, level of difficulty, comfort level, level of knowledge, and usual course of action

Statistical Tests Used

- Descriptive statistics: frequencies, percentages, mean, median

Results

- N=202: Mean age 46 years; 53% Nurses, 26% Physicians, 10.9% Nurse Practitioners, 5.5% Dentists
- Only 27% identified the correct number to report a case
- 49% did not feel comfortable with knowledge of Indiana Law
- Only 5% found it easy/very easy to identify child abuse/neglect
- Highest barriers cited: lack of certainty (69%), concern for making it worse for child (48%), lack of follow up from CPS (35%), and uncertainty of reporting procedures (32%)

Conclusions

- Further education delivered by multiple methods should be delivered and offered to the medical community on topics including identification and correct reporting procedures of suspected child abuse/neglect.
- Collaboration is needed between Child Protective Services and the medical community to develop a more efficient and effective process for reporting and feedback.
- Institutional polices should be established and consistent with current state laws, written in clear language, and reviewed routinely with all involved in the care of children.

Performance Improvement Category

IMPROVING DIABETES CARE IN A RESIDENCY - Primary Author: Dan Fisher, MD; Co-Authors: Ashley Williams, MD; David Paz, MD; Holly Wheeler, DO; Benjamin Abratigue, MD; Yousuf Baig, MD | Community Health Network Family Medicine Residency, Indianapolis

Find –This project was focused on Residents obtaining benchmarks in appropriately treating diabetes. Our clinic treats a large diabetic population and how well appropriate care is provided is essential as clinical performance is going to be measured in the future by many entities.

Organize – This project was conducted in conjunction by our program director, six residents, two advisors, and a data analyst.

Clarify – The previous process relied on resident's own personal knowledge of recommended diabetes care and their ability to identify that all recommendations were met.

Understand – Outcomes varied based on resident's knowledge, chart reviewing abilities, whether they were the PCP, and if the patient had been seen for diabetes care or only "quick sick" visits.

Select – Steps in the process that could be change were in how and what we identified as deficiencies in care. Once identified, these deficiencies needed to be corrected

Plan – A set of benchmarks was selected and a process for obtaining these benchmarks was developed.

Do –This change was implemented using our Care Managers to review patients' charts that included diabetes diagnosis code and team members as the PCP. They identified missing labs and services that could be obtained before office visit. Residents' implemented the use of "smart text" in their notes which contained areas to enter what services that had been obtained and which were still needed.

Check –Outcomes measured were performing bench marks provided by the AAFP Metric module. The outcomes measured were percentages of patients who had HgA1c, urine micro-albumin, lipid profile, or blood pressure measured in last 12 months and if patient had received services including retinal exam, foot exam, flu shot, or smoking cessation counseling in last 12 months.

Act – Compliance with benchmarks showed an increase. A greater increase in labs and services being obtained was demonstrated.

Case Presentation Category

HYPERALDOSTERONISM AND RESISTANT HYPERTENSION - Primary Author: David Emanuel Paz, MD; Co-Author: Karl Ost, MD | Community Health Network Family Medicine Residency, Indianapolis

Objective – Resistant Hypertension in the United States is significant and increasing. Overall, between 2005 and 2008 20.7% of all hypertensive patients met criteria for Resistant Hypertension. Up to 20% of Resistant Hypertension cases were due to Primary Aldosteronism. This case will discuss a typical presentation, evaluation and management.

Case—E.S. is a 66yo African-American female who has been hypertensive since she was a teenager. She presents for the management of her HTN after switching providers. She is currently on the following medications: amlodipine, hydralazine, metoprolol, hydrochlorothiazide, clonidine and losartan. She is also taking KCl 10mEq and has done so for over 25 years. Her Potassium levels are normal only with supplementation. Despite compliance with her multiple blood pressure medications her BPs on average is: 162/82. Per guidelines on Resistant Hypertension E.S. was screened for Primary Aldosteronism and her Aldosterone/Renin Ratio was 42.9 (> 28.9) with a suppressed renin level.

Discussion- It is not uncommon to have in our patient panels multiple patients with Hypertension who are in 3 or more medications and yet, are not controlled. This has prompted the question: why aren't our patients controlled? According to NHANES study the percentages of patient with Resistant Hypertension are increasing and so this scenario will become even more frequent. While it is not recommended to screen every hypertensive patient for Aldosteronism, it is a recommendation for those with Resistant Hypertension, Severe Hypertension, Hypokalemia, Hypertension with adrenal incidentalomas, Hypertension with a family history of early-onset hypertension or CVA, and all first-degree relatives of those that are known to have Hyperaldosteronism.
In the case of E.S. she received further CT evaluation demonstrating Aldosteronoma. However, because of her age, personal choices and masses being present bilaterally a decision was made to treat medically only. She was started on Aldosterone blocker. Shortly thereafter her BP normalized. In subsequent months blood pressure medications have been removed while her BP remained stable. Currently, she is on 2 anti-hypertensives and her BP is on average 125/85.

Conclusion- Hypertension is an epidemic affecting at least 65 million Americans. As many as 13.5 million Americans have Resistant Hypertension. They are often on multiple medications, which can be expensive, and their BP often remains uncontrolled. According to the Department of Health and Human Services, Hypertension costs the U.S. $156 billion in 2012 alone. Per recent studies Aldosteronism is underdiagnosed and may be as many as 20% of those with Resistant Hypertension. A simple screening test can lead to diagnosing these patients and then provide them with relatively simple, yet effective management.